STATEMENT OF
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VETERANS AFFAIRS AND REHABILITATION DIVISION
THE AMERICAN LEGION
TO THE
COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES HOUSE OF REPRESENTATIVES
ON
THE LONG TERM CARE POLICIES OF
THE DEPARTMENT OF VETERANS AFFAIRS

JANUARY 28, 2004

Mr. Chairman and Members of the Committee:

Thank you for this opportunity to share The American Legion's views on the Long Term Care policies of the Department of Veterans Affairs. We commend the Committee for holding this hearing to discuss these important issues.

BACKGROUND AND DEMOGRAPHICS

Department of Veterans Affairs' (VA) Long Term Care (LTC) has been the subject of discussion and legislation for nearly twenty years. In a landmark July 1984 study, ***Caring for the Older Veteran***, it was predicted that a 445 percent increase over 1980 in the numbers of veterans aged 75 and older would occur by the year 2000 and that 21.3 percent of all veterans in 2010 would be 75 or over compared to 3 percent in 1980. The study projected the Average Daily Census (ADC) in VA institutional LTC as 80,000 in 1990 with peak demand occurring in 2010 at between 110,000 and 140,000. In 1980, approximately 28 percent of all males 65 and over were veterans and the study projected that would increase to 62 percent by 2000. It was further estimated that demand for non-institutional care, not widely available in America at that time, could approach 790,000 veterans. This "wave" of elderly World War II and Korean Conflict veterans would occur some 20 years ahead of the general patient population and had the potential to overwhelm the VA LTC system if not properly planned for.

The most recent available data from VA, 2000 Census-based VETPOP 2001 Adjusted, shows there were 25.6 million veterans in 2002. Of that number, 9.76 million, or 37 percent, are age 65 or older. According to the 2001 National Survey of Veterans, the average age of all veterans was 58 years. More specifically, just 21.1 percent of the veteran population was under the age of 45, 41.2 percent were between the ages of 45 and 64, and 37.1 percent of the population was 65 years or older. The percentage of veterans 65 and older is significantly lower than the 62 percent projected by the 1984 study.

These findings do reflect the continuing trend of the aging veteran population; however, in comparison to the 1992 veteran population, the percentage of veterans in the youngest age cohort decreased (21 percent vs. 32 percent), the age percentage of the oldest age cohort increased (38

percent vs. 26 percent), and the middle cohort remained virtually unchanged (42 percent vs. 41 percent). Gender comparisons show that almost 4 in 5 male veterans are 45 years and older. This percentage of male veterans over 45 reflects their participation in the major wars of the last century. In contrast, female veterans tend to be younger. More than half of female veterans are under the age of 45. This gender difference between male and female veterans is due in part to the fact that females did not enter into the armed forces in great numbers until 1975. However, there is also a smaller peak in the female veteran age distribution at the older ages, reflecting their participation in WWII. Approximately 12 percent of female veterans are 75 years or older.

Veterans with service-connected disabilities rated 70 percent or higher have priority for VA institutional LTC under current law. In 2000, there were 328,363 such veterans. VETPOP2001 Adjusted projects this number to increase to 462,581 by 2010 and 533,695 by 2020, representing 29.1 percent and 39.5 percent increases over 2000, respectively.

VHA'S LONG TERM CARE PLAN

In April 1999, then Undersecretary of Veterans Affairs for Health, Dr. Kenneth Kizer and others issued ***A Strategic Plan for Long Term Care Provided by the Veterans Health Administration***. In the introduction, the Plan implied that the "wave" forecast in the 1984 study had arrived and that VHA was now confronted with a " 'demographic imperative' that the rest of American society will confront in another 15 or 20 years (i.e., a burgeoning population of elderly persons needing both acute and long-term healthcare services)…." and that the "imminent need to provide a coherent and comprehensive approach to long-term care for veterans will severely strain the VA health care system and will require significant increased funding."

In the Plan, VHA defined LTC as the continuing care needs of the person, as determined by their functional status. A number of Strategic Actions were outlined in the Plan including:

- Financial incentives and performance measures for Veterans Integrated Service Networks (VISN). The refinement of the VA LTC Planning Model, Planning for VA LTC should be based on Priority Groups 1-6 veterans and modeling for Priority Group 7 veterans (*prior to creation of Priority Group 8 veterans*) should include analysis of co-payments, coinsurance and insurance. This coverage was to have been initiated by VA, if deemed feasible.
- Retention of core in-house LTC services with most new demand for LTC being met through non-institutional services, contracting and State Veterans Homes (SVHs),
- Preference was to have been given to Home and Community-Based Care (HCBC), as defined in the basic benefits package, when clinically appropriate.
- VA was to have increased its investment in HCBC from 2.5 percent to 7.5 percent of the VA medical care budget, increased the FY 2000 – FY 2003 budgets for HCBC by $106 million per fiscal year and $30 million per FY for four years for new and innovative HCBC models with emphasis on community provider partnerships.
- Within VA LTC spending, HCBC was to double to 35 percent of LTC expenditures and legislative authority was to be sought for budget initiatives for new Facilitated Residential Living programs.
- VA was tasked to develop a policy on contract Community Nursing Homes (CNH) based on patient needs rather than one-size-fits-all contract lengths based on fiscal goals.

- Veterans with continuing needs and whose VA NHUs stays exceed 1000 days should be allowed to remain if they so desire, the current limitation being arbitrary.
- VA should not seek funding for new NHUs, except where justified by objective measures and national policy. A redesigned SVH construction grant prioritization methodology was to be advanced.
- VA was to have developed a standardized core patient assessment model using Resident Assessment Instrument/Minimum Data Set (RAI/MDS) input by Geriatric Evaluation Management (GEM) Teams.

The Plan also called for VA to seek legislative authority for broadened respite care, payment of Assisted Living/Residential Care and a new Medicare-like 100 days/patient/year nursing home benefit following a period of VA hospitalization. Additional ideas called for enhanced LTC/mental health staff collaboration, research and geriatrics education initiatives, and incentives to VISNs for lowering costs and increasing services offered and the development of a LTC Quality Index.

EXPANSION OF LONG TERM CARE ELIGIBILITY

On November 30, 1999, the President signed into law the Veterans Millennium Health Care and Benefits Act of 1999, P.L. 106-117, 113 Stat. 1545 (1999), (Millennium Act) which provided VA authority to implement some aspects of VHA's Long Term Care Plan.

Section 101 of the Act mandates VA to provide nursing home care to any veteran who requires it due to a service-connected disability and any vet with a disability rating 70 percent or higher. Certain other veterans are also eligible for VA NHU care. It also provides that any veteran currently in a VA NHU who continues to need care cannot be transferred to a SVH or contract nursing home without his or her consent. It further redefined "medical services" to include non-institutional Extended Care Services (ECS) provided either directly by VA, contract or third party providers/payers.

The Millennium Act directs VA to operate and maintain a program to provide ECS subject to 38 U.S.C. § 1710(a)(4): "effective in any fiscal year only to the extent and in the amounts provided in advance in appropriations Acts for such purposes." For ECS for the general, non-service connected veteran population, copayments may be required except where the veteran meets certain annual income limitation criteria (means testing) or is receiving a non-service connected VA pension based on wartime service, limited assets and permanent and total disability. The Millennium Act directs VA to develop a methodology for determining the amounts of copayments and establishes VA's Extended Care Fund, a Treasury revolving fund, into which copayments are to be deposited. Copayments for Extended Care Service were published October 4, 2001. Final regulations were published May 17, 2002, and became effective June 17, 2002. Implementation began at the end of July 2002. No deposits to the fund are shown either in the FY 2002 actual VA healthcare business-line budget or in the FY 2003 or FY 2004 estimated budgets. VHA Directive 2002-008, Extended Care Fund, was published in February 2002 and provides financial policy and procedures for VA's Extended Care Fund.

Statutory entitlement to VA's ECS under the Millennium Act does not necessarily mean that a veteran will be automatically admitted to a VA NHU, SVH or CNH. VHA Directive 2000-044, November 14, 2000, requires that VA facilities determine the need for nursing home care based on a comprehensive interdisciplinary clinical assessment. Where it is clinically appropriate, eligible patients are placed initially in the least restrictive, lowest cost environment; Home and Community Based Care (HCBC). Patients admitted to VA NCUs or CHNs on or after the Millennium Act date of enactment may be transferred to HCBC or assisted living facilities only when it is clinically determined that the patient no longer needs inpatient care at any level. An attachment to the Directive, **Policy Guidelines for Continuity of Care Planning for VA Long Term Care Inpatient Units**, states as a principle that while fiscal constraints and competing priorities exist, transfer decisions should not be based solely on cost considerations.

INSTITUTIONAL CARE

Nursing Homes

Except for the occasional congressional initiative to build nursing homes in individual states or congressional districts and some CARES planning initiatives, VA has no plans to expand its own nursing home capacity. On the contrary, it is apparent that VA intends to get out of the nursing homes business to the extent possible. It was charged in the House Veterans' Affairs Committee's (HVAC) FY 2004 Budget *Views and Estimates* that VA plans to do away with a large part of its existing LTC beds, to wit:

> The Committee has been in regular communication with the Secretary concerning a noted decline in VA nursing home beds (approximately 2,000 beds). On May 8, 2002 the Secretary made a commitment to restore these beds to their prior level, provided that Congress appropriates an increase in VA's medical care appropriation for fiscal year 2003. In the omnibus appropriation approved by Congress on February 13, 2003, VA received $1.1 billion more than what was requested by the President for the period.
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> The Committee is disappointed by the Secretary's proposal in this budget to close thousands of additional VA nursing home beds. VA's own long-term care model, based on the medical needs of its users, indicated a need for 17,000 new nursing home beds by 2020. The Committee does not believe that VA can replace 5,000 nursing home beds with outpatient programs for elderly, chronically ill veterans.
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> VA has failed to fulfill the promise of its landmark mid-1980's study, ***Caring for the Older Veteran***. That study recommended large increases in both inpatient and alternative programs, such as respite, hospice, adult-day and home-based care, so that VA could approach the needs of World War II veterans with meaningful, health and end-of-life care programs, on both institutional and non-institutional bases. This has not been achieved.
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> In order to aid the Department in maintaining its current nursing home bed level, the Committee recommended VA's budget request be augmented by an additional $297

million. Furthermore, VA should fund effective alternatives to long-term care and reopen long-term care nursing beds that have been closed.

The Millennium Act required VA to maintain its in-house NHU bed capacity at the 1998 level of 13,391. This capacity has significantly eroded rather than been maintained. In 1999 there were 12,653 VA NHU beds, 11,812 in 2000, 11,672 in 2001 and 11,969 in 2002. VA estimates it will have only 9,900 beds in 2003 and 8,500 in 2004. VA has claimed that it cannot maintain both the mandated bed capacity and implement all the non-institutional programs required by the Millennium Act.

In a February 2002 letter to HVAC Ranking Democratic Member Lane Evans, VA Secretary Anthony Principi stated:

> "I have come to the conclusion that as long as we continue to use VA inpatient average daily census (ADC) as the singular measure for long-term care capacity, it will not be possible for VA to meet the requirements of P.L. 106-117 without adversely affecting our ability to provide other essential health care services to veterans on a timely basis."

On March 20, 2002, VA Secretary Principi forwarded a plan to HVAC to restore VA NHU bed capacity to the 1998 level including "substantial implications" for doing so. The cost was to be offset by forgoing planned expansion of contract community nursing care, decreasing education and research programs, reprogramming technology infrastructure requirements, transferring a portion of the SVH construction budget and converting intermediate medicine beds to NHU beds. Following these "threats", HVAC replied on March 26 that it was prepared to recommend appropriation of additional funds to enable VA to comply with the law.

An examination of the **VA Long Term Care Fact Sheet** from June 2003 shows that State Veterans Homes ADCs will have risen between 1999 and 2004 (estimated) by approximately the same number of veterans as the decline in VA's NHU ADC. The Fact Sheet came out more than a full year after the HVAC-SecVA exchanges began and the additional funding promised by HVAC has not materialized.

VA has historically had strong LTC programs and capability, and should be required to maintain its nursing home capacity as intended by Congress. VA must create incentives and receive appropriate funding to maintain its NHCU beds rather than abandon them to alternative sources. These beds are a vital component of the VA LTC continuum of care, and they are essential in addressing the LTC needs of the aging veteran population.

According to VA's FY 2002 Annual Accountability Report Statistical Appendix, in September 2002, there were 93,071 World War II and Korean War era veterans receiving compensation for service-connected disabilities rated seventy percent or higher. The American Legion believes that VA should comply with the intent of Congress to maintain an adequate LTC nursing home capacity for those disabled veterans who are in the most resource intensive groups; clinically complex, special care, extensive care and special rehabilitation case mix groups. The nation has a special obligation to these veterans. They are entitled to the best care that the VA has to offer.

Assisted Living Pilot Program

Section 103 of The Millennium Act authorizes VA to establish a three-year assisted living pilot program by allowing VA to enter into six-month contracts with Assisted Living Facilities (ALFs) for eligible veterans who require assistance with ADLs and would otherwise require ongoing VA nursing home care. The Assisted Living Pilot was awarded to VISN 20 (Oregon, Washington, Idaho, and Alaska), which began implementation of the clinical demonstration in early 2002. Evaluation will be by VA's Health Services Research Centers of Excellence and a report will be submitted October 2004. Legislation (S.1572) is currently pending in the 108th Congress that would expand these pilots to an additional three VISNs.

State Veterans Homes

Per diems

Since 1984, nearly all planning for VA inpatient nursing home care has revolved around State Veterans Homes and contracts with public and private Nursing Homes. The reason for this is obvious; VA pays a per diem of only $59.48 (FY 2004 estimate) for each veteran it places in SVHs, compared to the $354.00 VA says it cost in FY 2002 to maintain a veteran for one day in its own NHUs. In the same letter in which HVAC promised more funding, this figure was questioned. VA confirmed that the amount was correct. In his reply, Secretary Principi explained that VA NHUs employ experienced nursing staff with paid salaries comparable to state or regional locality pay rates and that VA tends to fill vacancies with registered nurses rather than less skilled workers. These staffing decisions "have been supported by the patient assessment data. In FY 2001, 79 percent of veterans served in [VA NHUs] were in the clinically complex, special care, extensive care and special rehabilitation case mix groups. These groups are the four highest resource intensive categories, resulting in a higher cost of care." SVHs, on the other hand, are required to provide the same levels of care to an increasing Average Daily Census of veterans for the VA per diem, plus whatever Medicaid, private insurance and veteran copayments are available. Any shortfall in SVH operating revenue must come from private donations and state treasuries.

Currently, VA pays 70 percent of charges when it places a veteran in a contract nursing home. VA should consider utilizing State Veterans Homes and reimbursing them the same 70 percent that is charged by contracted facilities.

Many states require that per diems paid to SVHs be offset to the state's Medicaid fund. The American Legion believes that this practice defeats the purpose of providing the per diem and has the effect of lowering the quality of care afforded veterans. This issue has been the subject of congressional effort in the past. In 1986, identical bills were introduced in the House and Senate that would have precluded SVH per diem from being considered third-party liabilities. The Senate bill passed; the House bill did not. In its report, the Senate Veterans' Affairs Committee stated that, "VA per diem payments should increase the resources available to eligible veterans – not simply reduce the amount of Medicaid payments to the Homes." The American Legion believes that, in light of escalating health care costs to SVHs, it is time to revisit this issue.

Pharmaceutical benefits
Currently, veterans with service-connected disabilities rated 50 percent or greater receive VA pharmaceutical benefits at no cost. Veterans in SVHs also receive this benefit but are required to travel to VA facilities to obtain their medications. This practice places an unnecessary burden on many frail, elderly SVH residents. It is the position of The American Legion that these veterans should receive their prescription and over-the- counter medications at their places of residence.

Construction grant program
The Millennium Act required VA to develop a methodology for determining the greatest levels of need when prioritizing SVH construction grants based on a 10-year projection of veterans over 65 in each State. Those need levels were to be classified as "great", "significant" or "limited", depending on the existing SVH bed inventory, eligible veteran population and prior grants for each State. A priority scale was then mandated by the Act, designating in which order grant applications were to be granted:

1. A SVH requiring life safety, utility or structural upgrades
2. Applications from States that have never applied in the past.
3. Applications from a State having great need.
4. A SVH requiring other renovations.
5. Applications from a State having significant need.
6. Applications meeting other criteria as determined appropriate by VA.
7. Applications from a State having limited need.

The **State Home Construction Grants 2003 Priority List** prioritizes 81 projects to be funded at 65 percent of cost to build for a total VA outlay of $379 million. Of those, 25 add 3529 new beds to SVH capacity and the remainders are renovations or the outright replacement of existing facilities. If this activity continues at the current level for the next five years, over 17,000 new SVH beds will be available. **The FY 2003 VHA Baseline Health Care Demand Model** projects total VA nursing home ADC of approximately 53,000 in FY 2012, including SVHs, VA NHUs and contract homes. Currently, there are 42,329 veterans in VA institutional care of all types.

Interestingly, the Skilled Nursing Facility (SNF) industry has already begun to complain that SVHs are lowering their occupancy rates. Many states have Certificate of Public Need (COPN) laws requiring needs-based justification for the construction of new medical infrastructure. In Texas, a recipient of numerous new SVH grants, a moratorium is in effect on the construction of new SNF Medicaid beds. State governments may or may not be subject to their own COPN laws. According to a LTC trade publication, ***Provider Magazine*** (June 2002), there are 22,000 empty SNF beds in Texas for an occupancy rate of 74 percent. The article calls the situation in Texas a microcosm for the rest of the country where SNF occupancy rates are dropping (88 percent in March 2002 according to Centers for Medicare and Medicaid Services).

Community Nursing Home Providers

In 2001, VA contracted with approximately 2,500 private SNFs for the long term care of 3,960 veterans, an increase over 2000, but a marked decline from 1998 and 1999. This number is

expected to increase, as veterans more often want to be close to family, something that is not always possible with VA NHUs and SVHs. VA currently pays 70 percent of contract NH charges. Contracts are entered into by local VA medical centers (VAMCs) or regionally at the VISN level. Regional level contracts appear to offer the most flexibility for the veteran because they are usually entered into with larger LTC firms that guarantee care to veterans at any facility nationwide.

NON-INSTITUTIONAL CARE

VA provides a wide range of services as alternatives to inpatient nursing home care for all enrolled veterans.

Home-Based Primary Care

This program (formerly Hospital Based Home Care) began in 1970 and provides long-term primary medical care to chronically ill veterans in their own homes under the coordinated care of an interdisciplinary treatment team. This program has led to guidelines for medical education in home care, use of emerging technology in home care and improved care for veterans with dementia and their families who support them. In 2002, home-based primary care programs were located in 76 VA medical centers.

Contract Home Health Care

Professional home care services, mostly nursing services, are purchased from private-sector providers at many VA medical centers. The program is commonly called "fee basis" home care.

Adult Day Health Care (ADHC)

Adult Day Health Care programs provide health maintenance and rehabilitative services to veterans in a group setting during daytime hours. VA introduced this program in 1985. In 2002, VA operated 21 programs directly and provided contract ADHC services at 80 VA medical centers. Two state homes have requested VA recognition to provide ADHC, which has recently been authorized under the State Home Per Diem Program.

Homemaker and Home Health Aide (H/HHA)

In 1993, VA began a program of health-related services for service-connected veterans needing nursing home care. These services are provided in the community by public and private agencies under a system of case management provided directly by VA staff. VA purchased H/HHA services at 120 medical centers in 2002.

Community Residential Care

The community residential care program provides room, board, limited personal care and supervision to veterans who do not require hospital or nursing home care but are not able to live independently because of medical or psychiatric conditions, and who have no family to provide care. The veteran pays for the cost of this living arrangement. VA's contribution is limited to the cost of administration and clinical services, which include inspection of the home and periodic visits to the veteran by VA health care professionals. Medical care is provided to the veteran primarily on an outpatient basis at VA facilities. Primarily focused on psychiatric

patients in the past, this program will be increasingly focused on older veterans with multiple chronic illnesses that can be managed in the home under proper care and supervision.

Respite Care

Respite care temporarily relieves the spouse or other caregiver from the burden of caring for a chronically ill or disabled veteran at home. In the past, respite care admission was limited to an institutional setting, typically a VA nursing home. The Millennium Act expanded respite care to home and other community settings. Currently, respite care programs are operating in 136 VA medical centers, with each program typically providing care to approximately five veterans on any given day. Respite care is usually limited to 30 days per year.

Domiciliary Care

Domiciliary care is a residential rehabilitation program that provides short-term rehabilitation and long-term health maintenance to veterans who require minimal medical care as they recover from medical, psychiatric or psychosocial problems. Most domiciliary patients return to the community after a period of rehabilitation. Domiciliary care is provided by VA and state homes. VA currently operates 43 facilities. State homes operate 51 domiciliaries in 33 states. VA also provides a number of psychiatric residential rehabilitation programs, including ones for veterans coping with post-traumatic stress disorder and substance abuse, and compensated work therapy or transitional residences for homeless chronically mentally ill veterans and veterans recovering from substance abuse.

Telehealth

For most of VA's non-institutional care, telehealth communication technology can play a major role in coordinating veterans' total care with the goal of maintaining independence. Telehealth offers the possibility of treating chronic illnesses cost-effectively while contributing to the patient satisfaction generally found with care available at home.

Subacute Care

This care is provided to veterans who require a level of care between acute and long-term care. These veterans are provided care in VA hospital intermediate bed sections.

Geriatric Evaluation and Management (GEM)

Older veterans with multiple medical, functional or psychosocial problems and those with particular geriatric problems receive assessment and treatment from an interdisciplinary team of VA health professionals. GEM services can be found on inpatient units, in outpatient clinics and in geriatric primary care clinics. In 2002, there were 57 inpatient GEM programs and more than 164,000 visits to GEM and geriatric primary care clinics.

Geriatric Research, Education and Clinical Centers (GRECC)

These centers increase the basic knowledge of aging for health care providers and improve the quality of care through the development of improved models of clinical services. Each GRECC has an identified focus of research in the basic biomedical, clinical and health services areas, such as the geriatric evaluation and management program. Medical and associated health students and staff in geriatrics and gerontology are trained at these centers. Begun in 1975, there

are now 21 GRECCs in all but two of VA's health care networks. Congress authorized VA to establish up to 25 of these centers.

All-Inclusive Care Pilot Program

Section 102 of the Millennium Act mandates that VA carry out three pilot programs to determine the effectiveness of different models of LTC for frail elderly veterans. The objective of the mandate is to reduce VA's reliance on hospital and nursing home LTC. The Millennium Act describes three different models to be used; directly by VA, direct VA and contract providers and direct VA and cooperative agreement with public and private providers. In-kind assistance to providers is authorized to reduce the cost to the government. The pilot programs include the full spectrum of non-institutional LTC including Adult Day Health Care (ADHC) eight hours per day, five days per week, medical services, coordination of care, transportation, home care and respite care. All-Inclusive Care Pilot sites were awarded to Denver, Columbia, SC, and Dayton VA facilities, which began implementing the clinical demonstrations in mid 2001. Evaluations will be done by VA Health Services Research Centers of Excellence, with a report to be submitted in March 2005. Current legislation (S. 836), pending in the 108th Congress, would extend these pilots an additional five years.

VA IMPLEMENATION OF NON-INSTITUTIONAL CARE PROGRAMS

On March 29, 2002, the General Accounting Office (GAO) issued a report that stated that nearly two years after The Millennium Act's passage, VA had not implemented its response to the Act's requirements that all eligible veterans be offered adult day health care, respite care and geriatric evaluation. At the time of GAO's inquiry access to these services was "far from universal." While VA served about one-third of its 3rd Quarter 2001 LTC workload (23,205 out of an ADC of 68,238) in non-institutional settings, it only spent 8 percent of its LTC budget on these services. Additionally, at the time of the report, VA had not even issued final regulations for non-institutional care, but was implementing the services by issuing internal policy directives, according to GAO. Of 140 VAMCs, only 100 or 71 percent were offering adult day health care in non-institutional settings. Almost all VAMCs provided respite care, but less than 40 offered it in a non-institutional setting. That is, the veteran was required to be admitted to a VA hospital in order to give home caregivers a break, rather than VA sending workers out to the veteran. Less than 90 VAMCs conducted geriatric evaluations and the venue was mixed; some offered evaluations only in hospitals, some in a non-institutional setting and some both.

By May 22, 2003, over one year later, GAO testified before the HVAC Subcommittee on Health that things had not improved and that veterans access to non-institutional LTC was still limited by service gaps and facility restrictions. The services offered now included home-based primary care, homemaker/home health aide services and skilled home health care. GAO's assessment now included the degree to which services were offered within the geographical region encompassed by the VAMCs, and services were found to be spotty within regions. For four of the six services, the majority of facilities either did not offer the service or did not provide access to all veterans living in the geographic service area. Veterans had the least access to respite care that was actually offered by fewer VAMCs than in 2001. GAO found that at least 9 VAMCs were illegally limiting veterans' eligibility to receive non-institutional LTC based on their

service-connected disability. 59 VAMCs had developed waiting lists for services based on eligibility restrictions. GAO summed up the problem nicely when it testified that " [f] aced with competing priorities and little guidance from headquarters, field officials have chosen to use available resources to address other priorities."

At the same hearing, VA Undersecretary for Health Dr. Robert Roswell acknowledged the GAO study was correct in its conclusion that implementation of non-institutional LTC services is incomplete and access is uneven over the system. He disagreed, however, with GAO's contention that VA has failed to emphasize access, citing the rise in non-institutional LTC ADC from 13, 407 in 1999 to an estimated 25,873 in 2004. Dr. Roswell further stated that GAO's position that every enrolled veteran should have equal access to every non-institutional care program regardless of location or circumstances is "unrealistic." He cited the availability of local providers, cost-effectiveness, implementation of care coordination on a broader scale and "reasons over which VA has no control." The American Legion believes that the intent of Congress in authorizing these programs to was to provide a continuum of care that matches the veteran with the least costly, most clinically appropriate services in the least restrictive environment. The key to compliance with congressional intent lies in mandatory funding of e VHA

MANDATORY FUNDING OF VETERANS HEALTH CARE

The American Legion believes that the solution to VHA's recurring fiscal difficulties will only be achieved when it's funding becomes a mandatory spending item. Funding for VA health care currently falls under discretionary spending within the Federal budget. VA health care budget competes with other agencies and programs for Federal dollars each year. The funding requirements of health care for service-disabled veterans are not guaranteed under discretionary spending. VA's ability to treat eligible veterans is dependent upon discretionary funding approval from Congress each year.

Under mandatory spending; however, VA health care would be funded by law for all enrollees who meet the eligibility requirements, guaranteeing yearly appropriations for the earned health care entitlement of veterans.

The American Legion believes it is disingenuous for the government to promise long term care to its aging veterans and then make it unattainable because of inadequate funding. Rationed health care is no way to honor America's obligation to the brave men and women who have, and continue to, unselfishly put our nation's priorities in front of their own needs. Mandatory funding for VA health care will help ensure timely access to quality health care for America's veterans.

Mr. Chairman, this concludes my submission for the record. I again thank the Committee for this opportunity to express the views of The American Legion on VA's Long Term Care Policies and I look forward to working with you on these important issues.